MEDICAL INSURANCE BENEFITS

A PROGRAMMED LEARNING TEXT

U.S. Department of Health and Human Services
Health Care Financing Administration

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THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries - approximately 47 million of the nation's aged, disabled and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

THE MEDICAID/MEDICARE MANAGEMENT INSTITUTE (M/MMI), within the Health Care Financing Administration, Bureau of Program Operations, works with Federal, State, and contractor staff toward improved management of the Medicaid and Medicare programs.

The M/MMI promotes program management improvements through problem analysis and technical assistance for corrective action, and fosters exchange of ideas and techniques through conferences, workshops, training and publications.

This booklet is intended primarily for those who need a basic understanding of Part B of Medicare, the Medical Insurance program. Information contained here is not all inclusive and does not alter or supersede regulations, operating procedures, or manual instructions.

Additional copies of this booklet can be obtained by contacting your servicing Health Care Financing Administration (HCFA) Regional Office or by writing to Health Care Financing Administration, Office of Management and Budget, Office of Human Resources and Administrative Services, 1710 Gwynn Oak Avenue, Baltimore, Maryland 21235.

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TO THE STUDENT

This is the third in a series of programmed learning texts covering the Health Insurance program. This text is limited to supplementary medical insurance provisions. Before working through this text, you should complete the first in the series, Medicare Enrollment, since the current text assumes knowledge of certain basic material presented in Medicare Enrollment. Also, it is preferred that the current text be studied after you have completed the second in the series, Hospital Insurance Benefits, but this is not mandatory.

This is not an examination, but a programmed learning text. You will get maximum benefit from it by following instructions carefully:

1. When a response is called for, write it in the space provided before checking your answer. This helps fix the correct answer in your memory.

2. If you choose an incorrect response, reread the frame or frames teaching that concept.

3. Proceed at your own best speed for reading and comprehension. Don't worry about how fast or slow someone else seems to be going. It is not necessary to complete this program in one session.

Most of the pages in the text require the use of an "answer mask," which is provided on the back cover. Place the mask on the page so it reveals only the top frame, covering the answers at the right. After you have selected your response, slide the mask down to expose the correct answer and the next frame. Proceed in this manner until you are instructed otherwise.

Medicare is a health insurance program for people 65 and older, for some people under 65 who are disabled, and for people of any age who have chronic renal disease. The program has two parts: hospital insurance (Part A) and supplementary medical insurance (Part B). READ ON	
Medicare's hospital insurance (Part A) can help pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility and for care at home by a home health agency. GO ON TO NEXT FRAME	
The supplementary medical insurance (SMI, or Part B) program helps pay for doctors' services, outpatient hospital services, medical services and supplies, home health services, outpatient physical therapy, and outpatient speech pathology. READ ON	
This programmed learning text will concentrate on the supplementary medical insurance program of Medicare. Hospital insurance (Part A) is discussed in a separate text: "Hospital Insurance Benefits - A Programmed Learning Text." GO ON TO NEXT FRAME	
_____ _____ _____ helps pay for doctors' services, outpatient hospital services, medical services and supplies, home health services, and outpatient physical therapy and speech pathology.	Supplementary medical insurance

SMI "helps" pay for these services -- the beneficiary is responsible for certain costs: a monthly premium, a yearly deductible, and 20% of the reasonable charges for covered services. GO ON TO NEXT FRAME	
First, the beneficiary is responsible for a monthly premium. Claire Meadowview is 65 and desires SMI coverage; she is responsible for a monthly _____. This monthly premium is reviewed annually and adjusted to reflect changes in the costs of the program.	premium
Second, the beneficiary must meet the Part B yearly deductible before Medicare will help pay for covered services. The SMI program does not pay for the first $60 of reasonable charges for covered services in a calendar year: the beneficiary is responsible for this first $60. This $60 is called the Part B yearly _____.	deductible
The third cost for which the beneficiary is responsible is 20% of reasonable charges (or reasonable costs). After the beneficiary has met the $60 yearly deductible, Medicare will generally pay 80% of the reasonable charges of most covered services furnished to an individual. In most cases Medicare pays _____ percent of the reasonable charges for covered medical services and supplies.	80
The three costs for which the beneficiary is responsible under Part B are: 1. _____ 2. _____ 3. _____	.Monthly Premium .Yearly Deductible .20% of reasonable charges

These costs will be discussed in greater detail later in the text, so keep them in mind. Now let's discuss some of the services that are and are not covered under Part B. GO ON TO NEXT FRAME	
Services of physicians are covered whether these services are performed in an office, the patient's home, a hospital, or other institution. Mary Jones is examined by a physician in his office. The physician's services _____ (are, are not) covered.	are
Surgery performed by a doctor in a hospital is covered under the SMI program because it is a service performed by a _____.	physician
The term "physician" includes doctors of medicine and osteopathy and, within certain limitations, doctors of dentistry, podiatry, and optometry, and a chiropractor legally authorized to practice by a State. GO ON TO NEXT FRAME	
The definition of a physician under SMI includes a dentist or oral surgeon only when surgery related to the jaw is performed. Dr. Walker, a dentist, performs surgery to repair a broken jawbone. Since this is within the SMI definition of a _____, his services are covered under SMI.	physician

John Bailey, a Doctor of Dental Surgery, submits a bill for dental work on George Watson, a Part B beneficiary. The itemized bill indicates that Dr. Bailey put in a full crown, a bridge, and repaired a partial upper plate. Will this bill be payable under Part B? Give your reasons. ANSWER BELOW	
No. For purposes of SMI, Dr. Bailey is considered a "physician" only when performing surgery related to the jaw. Crowns, bridges, and plate repair do not involve jaw surgery. GO ON TO NEXT FRAME	
The services of a podiatrist (or surgical chiropodist) are covered except for routine foot care, flat feet, and subluxation.* Nonroutine services, then, rendered by Dr. Cooper (a podiatrist) _____ covered by Part B. (are, are not) *Subluxation means partial dislocation or displacement of joint surfaces, tendons, ligaments, or muscles of the foot.	are
Those services of a podiatrist covered under SMI are the same services which would be covered if they were performed by a medical doctor (M.D.) or osteopath (D.O.), subject to the limits on services which the podiatrist is legally authorized to perform in the State in which licensed. Only those _____ services which a podiatrist is _____ authorized to perform by State law are covered under SMI.	nonroutine legally
A podiatrist's nonroutine services are covered whether they are performed in the podiatrist's office, the patient's home, a hospital, or an institution. John is treated by a podiatrist in the podiatrist's office. The podiatrist's services _____ covered. (are, are not)	are

Certain services which a podiatrist renders are <u>not</u> covered. These include routine foot care such as removal of corns, warts, or calluses, trimming of nails, treatment for flat feet, and treatment of partial dislocations of the foot. Paul visits a podiatrist to have a corn removed. This expense _____ covered. (is, is not)	is not
In review, services related to a condition of the foot, whether furnished by a podiatrist or a medical doctor, are covered under Part B except for _____ foot care, flat feet, and subluxations.	routine
The definition of a physician under SMI also extends to optometrists, but only for the purpose of attesting to a patient's need for prosthetic lenses (lenses used by persons lacking the natural lenses for their eyes). The optometrist also must be legally authorized by the State to practice optometry. GO ON TO NEXT FRAME	
Routine eye examinations for the purpose of prescribing, fitting, or changing eyeglasses are excluded from Medicare coverage. Eye refraction -- testing the eyes with various lenses and procedures to determine the correct eye prescription -- is also excluded from SMI coverage. READ ON	
Though eye refractions are not covered, prosthetic lenses prescribed for the beneficiary as a result of these tests would be covered. GO ON TO NEXT PAGE	

Dr. Seckler, a licensed optometrist, examined Al Smith, a Part B beneficiary. She determined that Al needed prosthetic lenses and therefore prescribed them for him. The prosthetic lenses _____ covered. (are, are not)	are
Dr. Seckler in this case is considered a _____ under Medicare because she attested to the need for the prosthetic lenses.	physician
Are the eye refractive services employed by Dr. Seckler in determining Mr. Smith's need for prosthetic lenses covered by Medicare? (yes, no)	no; refractive services are not covered under Part A or Part B.
For review then, an optometrist may be considered a physician only for the purpose of attesting to a patient's need for prosthetic lenses. Only the reasonable charge for the lenses will be covered, but not the _____ _____ service rendered in determining the need.	eye refractive
Services and supplies incident to services performed by physicians are also covered under SMI. Bill Harvey visits his physician, is examined, and given an injection of penicillin by the physician. The charge for the injection is also covered since it is _____ to the physician's services.	incident

Did you notice your answer should have read "incident to" and not "incidental to"? It is important to recognize that there is a technical difference in these 2 terms. The word "incidental" implies a chance occurrence or one of secondary importance, whereas, "_____ to" indicates a necessary relationship.	incident
Drugs or biologicals, then, are covered only if they cannot be _____ _____ and are incident to covered physicians' services.	self-administered
As a rule, drugs are not covered under Part B. They may be covered if they are _____ to covered physicians' services and cannot be _____ _____.	incident self-administered
Let's briefly review before proceeding. We have learned that the Part A program protects against the cost of hospital and related services, while the Part B program protects against the cost of _____ services and other medical costs.	physicians'
We have also learned that many services that are _____ to a physician's service, such as drugs and biologicals that cannot be self-administered, are covered under SMI.	incident

It was also pointed out that a dentist or oral surgeon can come under the definition of a "physician," when _____ related to the jaw is performed---	surgery
---and the same goes for a podiatrist if the services are _____ and the podiatrist is legally authorized to perform them by State law,	nonroutine
---and that the definition of "physician" can also extend to optometrists, but only in attesting to a patient's need for _____ _____. Now let's continue.	prosthetic lenses
Diagnostic laboratory services performed in a physician's office are always covered under SMI. Diagnostic laboratory tests performed in an independent clinical laboratory are covered if the laboratory meets standards set by the State or local agency responsible for licensing, and meets HEW standards as well. Even though a laboratory is licensed and approved by the State, it must also meet _____ provided by HHS regulations.	standards
Allbright Laboratories, Inc., is not licensed or approved by a State or local agency to perform diagnostic tests. In Allbright's State, there is no provision for licensing by State or local agencies. In this situation, Allbright may participate since there is no licensing or approving agency, but the laboratory must be certified as meeting HHS' _____.	standards

When there is no State or local provision for control of diagnostic laboratories, they _____ (do, do not) have to meet the requirement that they be licensed or approved.	do not
However, an independent clinical diagnostic laboratory must always meet the standards provided in _____ regulations.	HHS
Part B of Medicare also helps pay for surgical dressings, splints, casts, and other devices for the reduction of fractures and dislocations. Additionally, braces, artificial limbs, and artificial eyes are covered. GO ON TO NEXT FRAME	
It is decided that Mrs. Wilson needs an inhalation machine. Arrangements are made for its purchase on monthly installments. These installments are $75 and the reasonable monthly rental charge is determined to be $62. SMI will reimburse $_____ monthly until the reasonable charge for the purchase has been reimbursed.	$49.60 (80% of $62)
SMI will make periodic payments for durable medical equipment only for the period of time the equipment is determined to be medically necessary. In case of the patient's death, payments would stop since the equipment is no longer _____ _____.	medically necessary

Ambulance services are also covered, when other means of transportation would endanger the patient's health. Mr. Feilinger recently had abdominal surgery and is being released from the hospital to recuperate at home. His surgeon orders an ambulance to take him home because transporting him by other means would endanger Mr. Feilinger's health. This service _____ (is, is not) covered.	is
Dr. Ama tells Mrs. Smith that he will order an ambulance to take her to the hospital. He tells her she must remain in a reclining position until a complete examination is made. Since this ambulance service appears necessary, it probably _____ (would, would not) be covered under SMI.	would
William Bird elects to use an ambulance service for admission to a hospital because his son cannot get the day off to drive him there. He is able to get around well, and riding in an automobile is no problem for him. This would not be covered since other means of transportation would not _____ Mr. Bird's health.	endanger
Radiological therapy is also a service provided under SMI. This includes X-ray, radium, and radioactive isotope therapy. Jane Smith received cobalt treatments. These treatments are covered because this is a type of _____ therapy.	radiological or radioactive isotope
In addition to medical and other health services, certain home health services are also covered by Part B. Up to 100 home health visits per calendar year are covered under supplementary medical insurance in addition to the 100 home health visits covered under Part A (the _____ program). SMI covers 100% of the "reasonable costs" of home health services, after the deductible has been met.	hospital insurance

The 100 home health visits under SMI (Part B) are not related to a previous stay in a hospital or skilled nursing facility as they are under Part A. The _____ (how many) visits under Part B are counted during a calendar year.	100
Unlike the Part A program, the 100 home health visits provided under Part B are within a _____ year.	calendar
In addition to the above requirements, to receive covered home health services under Part B, a physician must establish a plan of treatment and certify that the person is confined to home and in need of intermittent skilled nursing care, or physical or speech therapy. Mr. Taylor is receiving skilled nursing care from a participating home health agency. He has never been to a hospital and has not been under the care of a physician because he says he does not believe in doctors. The Welfare Department arranged for the home health services. These services are covered. (True or False)	False; a physician must establish the plan and certify that he is homebound, etc.
The medical services covered under home health care are the same under both the HI and the SMI programs. The differences, then, are that under the SMI program:	
1. No prior stay in a _____ or _____ is required.	hospital, SNF
2. The 100 visits are within a _____ _____.	calendar year
GO ON TO NEXT PAGE	

We said that Part B pays for specified medical and other health services. Outpatient hospital services are included in this category. Outpatient services include diagnostic tests, such as diagnostic X-rays, pulmonary function tests, and urinalysis. Also included are outpatient therapeutic services, such as the setting of broken bones, plaster casts, minor surgery not requiring overnight hospitalization, and the treatment of burns, cuts, and abrasions. GO ON TO NEXT FRAME	
All outpatient services are included in Part B coverage. Therefore, a pulmonary function test performed for beneficary David King at the Appalachian Hospital's outpatient clinic is covered under _____.	Part B (or SMI)
John has an X-ray for a suspected fracture at the City Hospital outpatient service. This is _____ (covered/not covered) under Part B.	covered
Outpatient services are covered when rendered by a nonparticipating hospital, if they are emergency services which would have been covered had the hospital been a participating provider of services, and if the hospital meets certain minimum requirements. GO ON TO NEXT FRAME	
Morgan had his tonsils removed at the Plush Hospital Outpatient Clinic. This was not due to an emergency and the hospital is not participating in Medicare. The hospital service is _____ (covered/not covered).	not covered (although the physician's charge for the operation could be covered under Part B)

Outpatient physical therapy and speech pathology services are covered if furnished by, or under arrangements by, a participating provider of services. GO ON TO NEXT FRAME	
Outpatient _____ _____ and speech pathology services also may be provided by other parties under arrangements with, and under the supervision of, providers of services.	physical therapy
For purposes of outpatient physical therapy and speech pathology, the term _____ of _____ includes participating clinics, rehabilitation agencies, and public health agencies, as well as hospitals, skilled nursing facilities, and home health agencies.	provider, services
Outpatient physical therapy and speech pathology treatment rendered by providers of services may be furnished on the provider's premises, in the beneficiaries home, or in another health care institution. READ ON	
The physical therapy or speech pathology must be conducted according to a written plan established and reviewed periodically by a physician. The plan must prescribe the type, amount, frequency, and duration of the physical therapy or speech pathology services to be furnished. GO ON TO NEXT PAGE	

Services of a qualified physical therapist in independent practice are covered under the category "outpatient physical therapy benefits." GO ON TO NEXT FRAME	
Outpatient physical therapy is normally a covered service so long as the therapist has the required affiliation with Medicare, and there is a plan drawn up by a physician which prescribes the _____, _____, frequency and _____ of required treatment. The plan must also provide for periodic physician review.	type, amount, duration
However, outpatient physical therapy services of a qualified independently practicing therapist, if otherwise covered, must be rendered either in the therapist's office or in the beneficiarie's home. GO ON TO NEXT FRAME	
A physical therapist in independent practice would have to meet licensing and other prescribed standards (such as health and safety requirements) in order to have the service _____.	covered
Reimbursement for the services of a physical therapist in independent practice are limited to $100 of incurred expenses per calendar year. GO ON TO NEXT PAGE	

Jill Loper was confined to bed for 2 months in 1978 as a result of a serious fall. During this period, Jill received physical therapy services at home from a qualified physical therapist, practicing independently. The therapist charged Jill $150. Assuming that Jill's services were covered and that she has already met her Part B deductible, Jill could expect SMI to pay $_____ (how much) of her physical therapy expenses.	$80 (80% of $100 maximum incurred expenses in calendar year)
Certain medical and other health services (such as diagnostic tests, prosthetic devices, braces, X-ray therapy, physical therapy) that are ordinarily covered under Part A can be covered under Part B if the services were rendered to an inpatient in a qualified hospital or skilled nursing facility and the patient's eligibility has been exhausted, or the patient is not otherwise eligible, for Part A coverage. GO ON TO NEXT FRAME	
For these certain medical and other health services to be covered under Part B, they must be services which are normally covered under _____ _____ when furnished by a participating provider of services.	Part A (or hospital insurance)
Thus, if George Adams has used all his available days of hospital care under Part A and continues to be hospitalized, requiring a continuing series of X-rays and laboratory tests every week, he could be reimbursed under Part B for the X-ray services and laboratory services, because _____ _____ has run out.	Part A (or hospital insurance)
Likewise, if Jane Morehead has used all her Part A coverage but requires some X-rays while still in the hospital, this service will be covered under _____ _____ if she is enrolled.	Part B (or SMI)

Radiology and pathology services, rendered by physicians in these fields, are covered under SMI, even when performed for inpatients. SMI provides for payment of full reasonable charges for such radiology and pathological services rendered to hospital inpatients. The SMI deductible and coinsurance provisions _____ (do/do not) apply to radiological or pathological services rendered by physicians in these specialties to hospital inpatients.	do not
SMI provides for payment for diagnostic X-rays taken in the patient's home or in a nursing home, if they are taken under the general supervision of a physician and if they meet health and safety regulations. GO ON TO NEXT FRAME	
Portable X-rays are covered under SMI if they are taken under the general supervision of a _____ and meet health and safety regulations.	physician
The equipment used and the X-ray equipment operator's competency must meet _____ and _____ regulations.	health, safety
Reimbursement under both Part A and Part B will be made only for medically necessary covered items and services. In most instances of medical treatment we can assume medical necessity, but a physician's certification may be required for certain services. GO ON TO NEXT PAGE	

Generally, for most Part B services, diagnosis and treatment for illness or injury is involved, so we can assume medical _____ by inspecting the itemized bill.	necessity
Treatment in hospital outpatient departments is, in most instances, considered _____ _____ without a physician's certification.	medically necessary
A written certification by a physician could be required in some instances for covered services performed by non-physicians but under the supervision of a physician. Normally, medical necessity for these services can be determined from the itemized bill, so you should have relatively few cases requiring physician's certification under Part ___.	B
You must be aware, however, of those instances in which a claim is made for services which are not medically necessary. For example, a physician visits nursing home patients twice each day, although most of them are in good health and require no treatment or examination. This would be an example of services which are not _____ _____.	medically necessary
Public confidence in Medicare is directly related to the integrity of the program. All employees of the Health Care Financing Administration and of the intermediaries and carriers share a joint responsibility for early detection and referral of fraud and program abuse. The degree of public confidence shown in Medicare is directly related to the _____ of the program.	integrity

Cases involving either fraud or program abuse should be referred to the HCFA regional office. The Program Integrity Staff in the regional office is responsible for the development of all suspected violations and abuses involving Medicare benefits. GO ON TO NEXT FRAME	
You suspect that a clinic is charging twice (the beneficiary and Medicare) for the same service. You should do which one of the following? a. contact the clinic to make sure b. refer the matter in writing to the HCFA regional office	b.
There is a difference between fraud and program abuse. Fraud is a criminal violation of the Social Security Act which, upon conviction, can result in a fine or imprisonment. A beneficiary presents an Explanation of Medicare Benefits (EOMB) form which shows 12 office visits with a total charge of $200. The beneficiary claims to have been seen by the doctor only twice. This could be a case of _____ and you should _____ the matter to the HCFA regional office.	fraud refer
Any false statement or misrepresentation of material facts for use in determining a right to payment or the amount of payment is punishable by law. This is the definition of _____.	fraud
Program abuse is a concept that is not readily distinguishable. Generally, the term is used to describe incidents and practices, though not fraudulent, which may directly or indirectly cause financial losses to Medicare or to beneficiaries and their families. GO ON TO NEXT PAGE	

Dr. Cramer traditionally charges Medicare patients $15 for an office visit and her other patients only $12. This _____ an incident of program abuse. (is/is not)	is
Dr. Hanes conspires with his secretary to fabricate bills for services on Medicare beneficiaries when in fact these services were never rendered. These are program abuse acts. (True or False)	False. These are fraudulent acts
For most services covered by SMI, the individual will share part of the cost of the covered services. Under SMI the individual must pay _____ of the cost of incurred expenses.	part
GO ON TO NEXT PAGE	

Sophie visits Dr. Gleason every 6 months for a periodic routine physical examination. This type of service _____ covered by SMI. (is/is not)	is not
The date an expense is incurred is the date the service was rendered, rather than the date the bill for the service was received. GO ON TO NEXT FRAME	
Any expense for medical services received before the enrollee's coverage under SMI is not a covered expense. Carmen, age 65 in October 1979, enrolled for the SMI program in November 1979. Her coverage under the program begins 1/1/80. She was billed on 1/5/80 for medical services she received on 12/28/79. Since she was billed after her coverage under the program began, the expense would be a covered expense. (True of False)	False. The date the service was received was before her entitlement began.
Similarly, Jules enrolled for Part B in June 1979. He attains age 65 in August 1979. Any expense for services received before _____ is not covered.	8/1/79
For persons whose entitlement to SMI began July 1, 1977, the earliest expenses which can be covered are those incurred on _____.	7/1/77

What part of covered expenses will SMI pay for? Part B pays 80 percent of reasonable charges after the first $60 during a calendar year. The first $60 is called the deductible. After the deductible has been met, Part B pays 80 percent of the _____ _____ for covered expenses. (NOTE: Payment is 100 percent of reasonable costs for home health services and 100 percent of reasonable charges for certain pathology and radiology services.)	reasonable charges
The enrollee is responsible for the first $_____ of reasonable charges in each calendar year.	60
With certain exceptions, SMI will pay _____ percent of reasonable charges after the first $60.	80
Expenses incurred in the last 3 months of a calendar year which can be applied toward the deductible for that year are "carried over" to the following year, i.e., they are also applied toward the deductible for the following year. GO ON TO NEXT FRAME	
For example, Carmella's coverage under the SMI program began in July 1978. Her only covered expenses in 1978 were $20 for physician's services incurred in October. Carmella _____ count the $20 toward meeting the deductible in both 1978 and 1979. (may/may not)	may (if the $20 was considered as the reasonable charge)

If Carmella's covered expenses were $15 from July through September 1978, and $30 from October through December, she could then count $_____ toward meeting her deductible for 1979.	30
Under this provision, if covered expenses do not exceed $60 until the last 3 months of a calendar year, any expenses incurred in the last 3 months which count toward the deductible of that year can also be applied toward the deductible for the next year. For example, Gustaf had covered expenses of $10 in September 1978, and $1,000 in October and November. The $10 incurred in September can apply only to the $60 deductible for 1978, but the first $50 incurred in October may apply to both the 1978 and 1979 deductibles. GO ON TO NEXT FRAME	
George is enrolled in the SMI program and his coverage begins in January 1979. From January 1 through September 30, his covered expenses for medical services amount to $40. In the last 3 months of the year, they amount to $457. Since $20 of the incurred expenses were used in the last 3 months (October, November, December) to meet the $60 deductible for 1979, the $_____ can also be counted toward meeting the $60 deductible in 1980.	20
If George's covered expenses had been $60 in the period January 1 though September 30, none of the expenses incurred ($457) in October, November, and December could have been used in meeting the $_____ deductible for 1980.	60
If the deductible was met in the first 9 months of the year, then expenses incurred in the last _____ months cannot be "carried over" and applied toward the deductible in the following _____.	3 year

Assuming SMI coverage for the full year, show the amount of incurred expenses in 1978 used toward meeting the deductible in 1979. INCURRED EXPENSES 1978 — Jan. - Sept. / Oct. - Dec. — 1979 CARRYOVER $150.00 / $65.00 / _____ 40.00 / 90.00 / _____ 10.00 / 30.00 / _____ 60.00 / 15.00 / _____ none / 150.00 / _____	none $20.00 $30.00 none $60.00
After the deductible has been met, the SMI program pays 80 percent of the reasonable costs for covered Part B services provided by participating hospitals, skilled nursing facilities, and home health agencies. These organizations are called providers of services. Payments for services furnished by providers of services are based on reasonable costs. GO ON TO NEXT FRAME	
Part B payments made to providers of services are based on _____ _____. (There are some exceptions to this general rule which we will discuss later.)	reasonable costs
All Part B payments, other than those based on reasonable costs, are made on the basis of reasonable charges. For example, payment for a physician's services is based on reasonable _____.	charges
GO ON TO NEXT PAGE	

We have learned that when Part B services are furnished by a provider, the SMI payment will be 80 percent of _____ _____, after deducting any unmet portion of the deductible.	reasonable costs
Before we start the next section, let's review the way payments are made for Part B services. When a provider of services furnishes the Part B service, the payment is 80 percent of reasonable costs, and the provider may charge the patient 20 percent of the reasonable charges, after the deductible has been met. Providers must agree not to charge the patient more than 20 percent of the _____ _____ for covered services.	reasonable charges
The term "reasonable charge" has not been explained very thoroughly and yet has been used often in the preceding pages. Perhaps we can explain it somewhat better. A simple way to understand this concept is to remember that an "actual charge" by a physician or supplier of services is not necessarily the reasonable charge. READ ON	
The reasonable charge is a charge determined by the Medicare carrier and is based on a review of (1) "actual" charges, (2) customary charges, and (3) prevailing charges. The latter two are determined by the carrier through a review of charge history. The reasonable charge is defined as the lowest of the three. The reasonable charge is determined by the _____.	carrier
The actual charge is the amount that shows up on the physician's bill for services. The actual charge _____ be higher than the reasonable charge determined by the carrier. (may, may not)	may

The fact that a physician's actual charge may prove to be higher than the amount the carrier determines to be the reasonable charge is often the reason for the beneficiary's visit to a district office. GO ON TO NEXT FRAME	
Allan Krebs visits the DO complaining that a doctor bill for a $12 office visit that he paid and submitted to the carrier was reimbursed in an amount of only $8. He explained that his Part B deductible had been met. It is likely that the _____ charge was determined to be lower than the doctor's actual charge. The reasonable charge in this case is likely to have been $_____	reasonable $10 (80% of $10 = $8)
When a physician or supplier of covered Part B items or services accepts an "assignment" under Part B, there is an agreement to accept Medicare's reasonable charge determination as full payment. After the deductible, the beneficiary is responsible for _____ percent of the remaining reasonable charge.	20
We have just reviewed the two instances when a beneficiary's responsibility for payment is limited to 20 percent of the reasonable charge (after the deductible). This limitation applies when services are furnished by: 1. A _____ of services. 2. A _____ _____ _____ accepting assignment.	 provider physician or supplier
In situations where the physician or supplier of services does not agree to accept assignment and the beneficiary applies for reimbursement, the SMI program will still pay 80 percent of the reasonable charge above any unmet deductible, but there is no Medicare limitation on what the physician or supplier can charge the patient. GO ON TO NEXT PAGE	

A Part B "carrier" is an organization which has entered into an agreement with HCFA to perform specified administrative functions under the medical insurance program. One of these functions is determining reasonable charges and making payment to beneficiaries and/or physicians and other suppliers of Part B services.	
CONTINUE ON THE NEXT PAGE--YOU DO NOT HAVE TO USE YOUR MASK FOR THE NEXT SECTION. USE THE BLANK PORTION OF THE PAGES TO DO ANY NECESSARY FIGURING.	

ITEM 1 Under the Part A program, benefit payments are always made to the provider of services, and almost always through a fiscal intermediary. Under Part B, on the other hand, benefit payments may be made to physicians or other suppliers of covered goods and services, or directly to the individual, through carriers.

The payment of benefits based on "reasonable cost" is made directly to the providers of services by the same intermediary that handles Part A claims for that particular provider. The determination of what amount constitutes the "reasonable cost" for any covered service is one of the intermediary's most important functions. The concept of "reasonable cost" that the intermediary applies in making the determination in Part B claims is the same concept as is used for Part A under the hospital insurance program.

Benefit payments under SMI are made for 80 percent of the reasonable cost or reasonable charge of all covered services furnished an individual, except that the program does not pay any part of the first $60 of reasonable charges for incurred expenses in a calendar year (subject to the 3-month carryover). This means that, generally, the patient is responsible for the deductible, currently the first $60 of covered services furnished by a provider of services (such as a hospital or home health agency), and is responsible for 20 percent of the remaining reasonable charges for covered services.

Beneficiary Kay Wilson's first medical expense during 1977 was a bill for $40. This charge was made by a home health agency for services it furnished Kay. These services are covered by SMI. What amount of benefits were paid under the SMI program for these services?

a. 80 percent of the reasonable cost of the services. (See Item 2)

b. $32 (See Item 3)

c. Neither of the above is correct. (See Item 4)

ITEM 2 (1a) This answer would be correct only if Kay had already met her deductible for 1977. If she had already met the $60 deductible, benefits would be paid for 80 percent of the reasonable cost of the services because they were furnished by a provider of services. Since the $40 charge was Kay's first medical expense of the year, the 80 percent benefit payment cannot be made. Please return to Item 1 and choose another answer.

ITEM 3 (1b) Your answer is "$32." This would be correct only if (1) Kay had already met her $60 annual deductible for 1977, and (2) $40 was the reasonable cost of the services Kay received. Payment would have to be based on reasonable cost because Kay received the services from a provider of services. Please return to Item 1 and choose another answer.

ITEM 4 (1c) Correct. Actually no benefit payments can be made now because Kay has not yet met her $60 deductible for 1977. Since the $40 charge was for covered services, however, Kay's deductible has now been partially met. As soon as she incurs $20 more for covered services during the year, benefit payments under SMI begin.

ITEM 5 Medicare beneficiary Harry Shaffer has been furnished covered services in a physician's office. The reasonable charge for these services is $400. Rather than accepting assignment, Harry's physician sends him a bill for $435, which Harry pays. Assuming that Harry has previously incurred Part B medical expenses of $60 or more, which of the following is true?

a. Harry will receive $320 from the carrier. (See Item 6)

b. Harry will receive $328 from the carrier. (See Item 7)

ITEM 6 (5a) Very good! The carrier pays Mr. Shaffer because it was he who filed a claim for payment. He is paid 80 percent of the reasonable charge. Since the physician did not accept assignment, Mr. Shaffer is responsible for the difference between what is paid by Medicare and the physician's bill. In this case, the difference is $115. Go to Item 8.

ITEM 7 (5b) You computed the amount Harry would have received had $435 been considered the reasonable charge. However, $435 is what Harry is charged by his doctor. Although he will owe this bill, he will be reimbursed only on the basis of 80 percent of reasonable charges. Please review Item 1 and study the explanation to the correct answer found in Item 5.

ITEM 8 Payments for physicians' services can be made either to the patient or to the person who furnished the services. If the patient is to receive the benefit payment, the patient obtains an itemized bill, either paid or unpaid, from the doctor. The patient then presents the bill to the carrier, and is reimbursed for 80 percent of the reasonable charges submitted. Again, the carrier is responsible for determining what amount consitutes reasonable charges.

Medicare beneficiary Sally Thorn receives covered services from her physician. The carrier determined that the reasonable charges for the services Sally received were $50, but her physician's actual charge was $60. Sally paid the full $60 to her physician. Assuming that Sally already met the annual deductible for SMI benefits, which of the following statements will be true?

a. The carrier will pay Sally $40. (See Item 9)

b. The carrier will pay Sally $48. (See Item 10)

c. The carrier will pay Sally's doctor $40, and the doctor will refund $20 to Sally. (See Item 11)

ITEM 9 (a) Your answer is correct. The carrier will pay Sally $40 which is 80 percent of the reasonable charge for the services she received. The carrier reimburses the beneficiary 80 percent of reasonable charges for covered services. This is true whether the patient pays the physician and receives a receipted bill or whether the physician submits an itemized bill to the carrier. Now go on to Item 12.

ITEM 10 (8b) Since Sally submitted the physician's bill to the carrier herself, the carrier will make the benefit payments to Sally directly. However, the carrier will only pay for 80 percent of the reasonable charge for the services furnished by the physician. $48 is 80 percent of $60, the amount the physician actually charged. Return to Item 8 and choose another answer.

ITEM 11 (8c) Although the carrier will only pay 80 percent of the reasonable charge for services rendered by a physician, the payment of this benefit is made directly to the patient if the patient presents the itemized bill for the services. Please return to Item 8 and choose another answer.

ITEM 12 If the physician and patient agree, the patient may assign the benefit payment to the physician. This means that the carrier will make the benefit payment directly to the physician. Under the assignment, the physician agrees to accept the reasonable charge as the full charge for services rendered.

Going back to our previous example, let's assume that Sally assigned the benefit payment to her physician. Remember, the physician's charge for the services was $60, and the reasonable charge as determined by the carrier was $50. Which of the following statements is true?

a. The carrier will pay Sally's physician $50 and Sally will owe him nothing. (See Item 13)

b. The carrier will pay Sally's physician $40 and Sally will owe him nothing. (See Item 14)

c. The carrier will pay Sally's physician $40 and Sally will pay him $10. (See Item 15)

d. The carrier will pay Sally's physician $40 and Sally will pay him $20. (See Item 16)

ITEM 13 (12a) You say the carrier will pay Sally's physician $50. Let's think about this for a moment. The carrier has determined that $50 is the reasonable charge for the doctor's services. We also know that, under an assignment of benefits, the physician must accept the reasonable charge as full charge. However, benefit payments by a carrier direct to a personal physician are never the full reasonable charge for covered services, but are only 80 percent of that amount (after the deductible). Now return to Item 12 and choose another answer.

ITEM 14 (12b) You have correctly determined that the carrier will pay Sally's doctor $40, which is 80% of the reasonable charge for the covered services. However, the doctor is entitled to the full amount of the reasonable charge under an assignment. Please return to Item 12 and choose another answer.

ITEM 15 (12c) Good work! Under an assignment of benefits, the physician agrees not to accept more than the reasonable charge for his services. The carrier has determined that the reasonable charge for the services Sally received from her physician is $50. The carrier will pay the doctor 80 percent of the reasonable charge, or $40, and Sally is responsible for the remaining 20 percent of such reasonable charge, which is $10. Now go to Item 17.

ITEM 16 (12d) You are partially correct. The carrier will pay Sally's physician $40, which is 80 percent of the reasonable charge for the services she received. If Sally also pays the doctor $20, then he will have received $60, the full amount of his usual charge. Under an assignment, however, the physician must agree not to accept more than the reasonable charge for his services. Now return to Item 12 and choose another answer.

ITEM 17 The $60 deductible and 80 percent benefit computation rule apply, in general, to all services furnished under SMI during each calendar year. However, with respect to the treatment of mental, psychoneurotic, or personality disorders of an individual who is not a hospital inpatient, only $312.50, or 62 1/2 percent (whichever is smaller) of the expenses for physician services rendered in connection with such treatment can be counted as incurred expenses to which the $60 deductible and 80 percent rule apply.

Beneficiary Roger Dormant's first medical expense this year is for psychoanalytic treatment he receives from Dr. Westwood. The reasonable charge for these treatments is $300. What amount of benefits will be paid under SMI for these services? Roger is not a hospital patient. There is no deductible carryover from last year.

a. $150 (See Item 18)

b. $102 (See Item 19)

c. $120 (See Item 20)

ITEM 18 (17a) Your answer is "$150." This would be correct only if Roger had already met his $60 deductible for the year. Since these services were the first covered medical services Roger received during the year, the $60 deductible must be subtracted before benefit payments can be made. Please return to Item 17 and choose another answer.

ITEM 19 (17b) Excellent! $102 is correct. Since the psychiatric services Roger received were not furnished to him as a hospital inpatient, only 62 1/2 percent of the expenses incurred for physicians' services in connection with his treatment of a psychiatric condition can be considered covered by the SMI program. The amount of benefits payable is computed as follows:

62 1/2 percent of $300 = $187.50

$187.50 less $60 annual deductible = $127.50

80 percent of $127.50 = $102

ITEM 20 (17c) Your answer is $120. In arriving at this answer you remembered both to account for the $60 deductible and to apply the 62 1/2 percent limitation. However, you began by reducing the $300 by the $60 deductible, whereas you should have first taken 62 1/2 percent of $300, then accounted for the deductible. Return to Item 17 and choose another answer.

YOU WILL NEED YOUR MASK FOR THE NEXT SECTION

The form HCFA-1490, Request for Medicare Payment, may be completed and sent to the carrier as soon as expenses for covered services are incurred under SMI. However, no payment can be made until after the enrollee has satisfied the $_____ deductible.	60
June Smith completes HCFA-1490 and submits six itemized bills from Dr. Craft totaling $120. The carrier determines the reasonable charge to be $100. Assuming this is June's first claim this year, she will be reimbursed $_____.	32 ($100 - $60=$40; 80% of $40=$32)
Under the assignment method of reimbursement, the enrollee completes Part I of the HCFA-1490. If the physician or other supplier of covered services agrees to the assignment, they will complete Part II of the form and send it to the carrier. To use the assignment method, then, the physician or other supplier of covered services must _____ to the assignment in writing.	agree
Where assignment is agreed upon, the reimbursement is made to the doctor or other supplier of Part B services on a _____ charge basis.	reasonable
Under the assignment method, the doctor or other supplier of services must accept the reasonable charge determined by the _____ as the total fee for covered services.	carrier

Dr. Smith submits a HCFA-1490 for services rendered to Mary Katz in the amount of $150. The carrier determines the reasonable charges for these services to be $100. Dr. Smith must accept this determination. Assuming the $60 deductible is met, Dr. Smith may not bill Mary for more than $_____.	20 (20 percent of reasonable charges)
Dr. Smith will receive $_____ from the carrier on assignment.	80
Where the assignment method is used, the doctor or other suppliers of services must accept the reasonable _____ as determined by the _____.	charges, carrier
The two mthods for reimbursing under the SMI program are by _____ to the physician or payment to the _____.	assignment, beneficiary
The Request for Medicare Payment Form is the HCFA-_____.	1490 (See the next page for a sample of the form.)

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back — **Type or Print Information**)

Form Approved OMB No. 066-R-0012

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 405.1678)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

Copy from YOUR OWN HEALTH INSURANCE CARD ➡

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number *(Include all letters)*

☐ Male ☐ Female

3 Patient's complete mailing address (including Apt. no.) City, State, ZIP Code

Telephone Number

4 Describe the illness or injury for which you received treatment *(Always fill in this item if your doctor does not complete Part II below)*

Was your illness or injury connected with your employment?

☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency, show below

Name and address of organization or agency

Policy or Identification Number

Note: If you **Do Not** want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of patient *(See instructions on reverse where patient is unable to sign)*

Date signed

SIGN HERE ➡

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given (if lab service indicate if automated) — Procedure Code	D. Nature of illness or injury requiring services or supplies	E. Charges (if related to unusual circumstances explain in 7C)	Leave Blank
				$	

8 Name and address of physician or supplier *(Number and street, city, State, ZIP code)*

Telephone No.

9 Total charges $

Physician or supplier code

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill

➡ ☐ I accept assignment *(See reverse)* ☐ I do not accept assignment

13 Name and address of person or facility where services were furnished *(Complete if outside your own office or patient's residence)*

14 Signature of physician or supplier (I certify that the statements under Physicians' Notes on the reverse apply to this bill and are made a part hereof.)

➡

Date Signed

O—Doctor's Office IL—Independent Laboratory H—Patient's Home *(If portable X-ray services, identify the supplier)* IH—Inpatient Hospital SNF—Skilled Nursing Facility OH—Outpatient Hospital OL—Other Locations NH—Nursing Home

FORM HCFA-1490 (5-78) (FORMERLY SSA-1490) Department of Health and Human Services—Health Care Financing Administration

The next several pages will discuss two things: (1) the itemized bill that is submitted by the beneficiary (in non-assignment cases), and (2) the Explanation of Medicare Benefits (EOMB) that is generated by the carrier to explain the action taken as a result of bills submitted and processed. READ ON	
When the beneficiary is not "assigning" reimbursement directly to the physician, he/she completes Part I of the HCFA-1490 (items 1-6, preceding page). The beneficiary then has two options. First, he/she may attach the itemized bills from the physician and forward the form to the carrier. The second option for the beneficiary is to encourage the physician to complete Part II of the HCFA-1490. (This obviates the need for the beneficiary to attach itemized bills.) The form is then forwarded to the carrier. READ ON	
The itemized bill is the statement of charges completed by the physician or supplier of services indicating how much has been charged for covered services. In nonassignment requests for reimbursement, the beneficiary may attach itemized bills to the HCFA-_____, or have the physician complete Part II of the form.	1490
When itemized bills are attached, certain information should appear in <u>each</u> itemized bill to enable the carrier to process it for payment. First, proper identification is needed--the beneficiary's name and health insurance claim number (from the beneficiary's Medicare card). This is needed to associate the charges with the carrier's and SSA's records. GO ON TO NEXT FRAME	
The beneficiary's _____ and health insurance _____ _____ should appear on each itemized bill.	name claim number

Also, each itemized bill should show the date, location, and description of each service provided. This information helps the carrier determine whether the service is a covered one and helps in the determination of the reasonable charge. It is important to point out, however, that in unassigned cases, we cannot expect doctors to put sensitive diagnoses on a bill the patient sees. In these cases, physicians may complete Part II and send it directly to the carrier. READ ON	
Kurt Jensen submitted a physician's bill for $100 along with his completed HCFA-1490. The diagnosis was omitted, but since the service was described as "surgery," the carrier can assume it was serious enough to pay without additional information or diagnosis. (True or False?)	False. The carrier cannot determine if the surgery is covered and, if so, the amount of reimbursement, unless the bill or claims form contains information concerning the diagnosis and the specific surgical procedure performed.
Carl became entitled to SMI on 8/1/77. On September 5, 1977, he submitted a HCFA-1490 and an itemized bill for a covered service he received on 7/17/77. The carrier _____ reimburse Carl.	cannot. The date on the itemized bill tells the carrier that the service occurred before Carl's enrollment.
Finally, if there have been any unusual circumstances or complications causing a higher than usual charge to be made, this too should appear on the itemized bill (unless the information is sensitive and the doctor feels that the patient should not see it). The information is generally needed to assist in determining the reasonable charge for the service. GO ON TO NEXT FRAME	
If the charge for services has been affected by unusual _____ or _____, the description of them should normally appear on the _____ _____.	circumstances, complications, itemized bill

The term "office visit" is often considered a sufficient description of services on the itemized bill. The carrier will normally reimburse under this description unless there is reason for the carrier to believe that the services are not covered under Part B. GO ON TO NEXT FRAME	
The following pages contain samples of itemized bills with one or more errors and/or ambiguities. Find them and check your answer on the reverse of each page.	

ITEMIZED BILL

Leslie Ashe, M.D.
1015 Colburn Avenue
Rockville, Maryland 20850

Mr. Allen Jacobs
21 Eighth Street
Rockville, Maryland 20850

HI NO. 217-30-8752

STATEMENT

10-5	Office Visit	$10
	Diagnosis: High Blood Pressure	

1. INCOMPLETE HEALTH INSURANCE CLAIM NUMBER

2. IMPRECISE DATE OF SERVICE

ITEMIZED BILL

Morton Stein, M.D.
84 Oak Street
Buffalo, N.Y. 14203

Mr. John Hess
32 Bishop Street
Buffalo, N.Y. 14424

HI NO. 065-40-7401B

STATEMENT

11/29/78	Office Visit	$10

Diagnosis: Influenza

IMPROBABLE HEALTH INSURANCE CLAIM NUMBER
("Mr." is inconsistent with "B" claim symbol)

How is the beneficiary notified about the reimbursement made on the bills the beneficiary sends in? The beneficiary is mailed an Explanation of Medicare Benefits (EOMB). The EOMB is received by the beneficiary each time a claim is submitted regardless of whether submitted by the beneficiary or by the doctor in assignment cases. This form explains how the claim was processed and includes information on current deductible status. GO ON TO NEXT FRAME	
Alvin Krantz mailed several bills along with a competed HCFA-1490. Alvin can expect to receive an _____ _____ _____ _____ form explaining how his bills were processed for reimbursement.	Explanation of Medicare Benefits
The beneficiary can determine what amount of submitted bills were applied to the beneficiary's deductible by looking at the _____ mailed to the beneficiary following the carrier's processing of submitted bills. (initials)	EOMB
The EOMB also explains to the beneficiary when submitted bills were in excess of the reasonable charge for services rendered. Jean's bill for surgery in the amount of $500 was mailed to the carrier by the surgeon. The carrier determined that the _____ _____ for this service was $350 and reimbursed accordingly, explaining its action on an EOMB to John. The doctor, of course, is notified separately.	reasonable charge
The beneficiary, generally, would not understand the term "reasonable charge." It is a technical term which has a precise meaning for those who work with Medicare Part B reimbursement. GO ON TO NEXT PAGE	

Therefore, the term "reasonable charge" is rarely found on the EOMB. Instead the references are to "amount approved," which is more likely to be understood by the beneficiary. Most EOMB's substitute the terms "_____ _____" for reasonable charge.	amount approved
Social Security representatives are also encouraged to refrain from the use of the term _____ _____ in explanation of EOMB's to the beneficiary.	reasonable charges
Whether bills are submitted by the beneficiary, by the doctor, or by some other supplier of health care services, an EOMB is sent to the _____.	beneficiary
The explanation of Medicare Benefits form is usually a computer generated form and may be perplexing to those not used to seeing it. This is often the case for beneficiaries and is often the reason for their appearing at the DO for explanation. READ ON	
The next several pages are intended to familiarize you with the EOMB format.	

George Williams was billed $40 by Dr. Harrington for a diagnostic X-ray taken in the doctor's office on 4/1/78. George submitted an itemized bill to the carrier on a HCFA-1490. The amount was determined to be the reasonable charge and was allowed in full on 5/31/78. This was the first covered service received and submitted by George; thus, no Medicare payment was actually made to him. The $40 of allowed charges were simply applied toward his deductible. The EOMB below was mailed to George. Review it thoroughly and turn to the next page.

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM. KEEP THIS NOTICE FOR YOUR RECORDS

DATE	HEALTH INSURANCE NUMBER	CONTROL NUMBER
31 MAY 78	063-54-8852A	3122-25041 1

BENEFICIARY: GEORGE WILLIAMS

AMOUNT PAID:

BENEFITS HAVE BEEN PAID TO

GEORGE WILLIAMS
PO BOX 1284
HARTFORD CT 06125

FOR HEALTH INSURANCE
SOCIAL SECURITY ACT

THIS IS NOT A CHECK
DO NOT CASH

THE DOCTOR WHO BILLED GEORGE

THE AMOUNT GEORGE WAS BILLED

THE AMOUNT CHARGED WAS DETERMINED TO BE THE REASONABLE CHARGE FOR THE SERVICE

1. SERVICES WERE PROVIDED BY	2. WHEN FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	3. AMOUNT BILLED	4. AMOUNT APPROVED	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4. MEDICARE DOES NOT PAY FOR:	SERVICE CODES (see back)	CODE
DR HARRINGTON	04	01	8			40.00	40.00		1	D

THE DATE THE X-RAY WAS TAKEN

THIS IS NOT A BILL

THE $40 CHARGE WAS APPLIED TO GEORGE'S DEDUCTIBLE

TOTALS ►	40.00	40.00	MEDICARE PAID
Inpatient radiology and pathology physician services and certain laboratories paid in full ►			
Other approved charges, subject to the annual deductible ►			
This went toward satisfying the deductible ►		40.00	
The approved charges, minus the deductible, payable at 80% ►			
Date MAY 31, 1978 — TOTAL MEDICARE PAYMENT ►			

Please be sure to read the important information on the back of this notice. Use the enclosed Request for Medicare Payment form the next time you wish to claim Medicare benefits.

You have met $40.00 of the Deductible for 1978

Always use both numbers when writing about your claim.
HI Number 063-54-8852A
CO Number 3122-25041

NO PAYMENT WAS MADE TO GEORGE SINCE THIS WAS THE FIRST COVERED SERVICE RECEIVED IN 1978.

BENEFICIARY OR REPRESENTATIVE

REMARKS:

GEORGE WILLIAMS
PO BOX 1284
HARTFORD CT 06125

CODES FOR PLACE AND TYPE OF SERVICE

Place of Service (Left Column)

1 Office
2 Home
3 Inpatient Hospital
4 Skilled Nursing Facility
5 Outpatient Hospital
6 Independent Laboratory
7 Other Location
8 Nursing Home
9 Independent Kidney Disease Treatment Center

Type of Service (Right Column)

A Medical Care
B Surgery (Includes Treatment of Fractures)
C Consultation
D Diagnostic X-Ray
E Diagnostic Laboratory
F Radiation Therapy
G Anesthesia
H Assistance at Surgery
I Other Medical Service
J Whole Blood or Packed Red Blood Cells

Let's assume that the situation was the same except that George has already incurred $60 of covered services and has met his deductible. The EOMB would appear as below:

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM. KEEP THIS NOTICE FOR YOUR RECORDS

DATE	HEALTH INSURANCE NUMBER	CONTROL NUMBER
31 May 78	063-54-8852A	3122-25041 1

BENEFICIARY: GEORGE WILLIAMS

AMOUNT PAID

BENEFITS HAVE BEEN PAID TO

GEORGE WILLIAMS
P.O. BOX 1284
HARTFORD CT 06125

FOR HEALTH INSURANCE
SOCIAL SECURITY ACT

THIS IS NOT A CHECK
DO NOT CASH

1. SERVICES WERE PROVIDED BY	2. WHEN FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	3. AMOUNT BILLED	4. AMOUNT APPROVED	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4. MEDICARE DOES NOT PAY FOR:	SERVICE CODES (see back)	CODE
DR. HARRINGTON			04	01	8	40.00	40.00		1	D

THIS IS NOT A BILL

TOTALS ►	40.00	40.00	MEDICARE PAID	Please be sure to read the important information on the back of this notice. Use the enclosed Request for Medicare Payment form the next time you wish to claim Medicare benefits.
Inpatient radiology and pathology physician services and certain laboratories paid in full ►				
Other approved charges, subject to the annual deductible ►		40.00		
This went toward satisfying the deductible ►				You have met $60.00 of the Deductible for 1978
The approved charges, minus the deductible, payable at 80% ►		40.00	32.00	Always use both numbers when writing about your claim. HI Number 063-54-8852A
Date MAY 31, 1978 TOTAL MEDICARE PAYMENT ►			32.00	CO Number 3122-25041

REMARKS:

BENEFICIARY OR REPRESENTATIVE

GEORGE WILLIAMS
P.O. BOX 1284
HARTFORD CT 06125

Suppose the situation were the same as before except that George had received the service as a hospital inpatient. Do you remember that radiology and pathology services rendered by physicians to hospital inpatients are reimbursable at 100% of reasonable charges? The SMI deductible and coinsurance do not apply to these services. See how the EOMB appears below in George's case when he is in the hospital.

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM. KEEP THIS NOTICE FOR YOUR RECORDS

DATE	HEALTH INSURANCE NUMBER	CONTROL NUMBER
31 MAY 78	063-54-8852A	3122-25041 1
BENEFICIARY	GEORGE WILLIAMS	

AMOUNT PAID

BENEFITS HAVE BEEN PAID TO

DR ROBT HARRINGTON
4203 NORTH ST
HARTFORD CT 06125

FOR HEALTH INSURANCE
SOCIAL SECURITY ACT

THIS IS NOT A CHECK
DO NOT CASH

1. SERVICES WERE PROVIDED BY	2. WHEN FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	3. AMOUNT BILLED	4. AMOUNT APPROVED	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4. MEDICARE DOES NOT PAY FOR:	SERVICE CODES (see back)	CODE
DR HARRINGTON			04	01	8	40.00	40.00		3	D

THIS IS NOT A BILL

TOTALS ▶	40.00	40.00	MEDICARE PAID
Inpatient radiology and pathology physician services and certain laboratories paid in full ▶		40.00	40.00
Other approved charges, subject to the annual deductible ▶			
This went toward satisfying the deductible ▶			
The approved charges, minus the deductible, payable at 80% ▶			
Date MAY 31, 1978 TOTAL MEDICARE PAYMENT ▶			40.00

Please be sure to read the important information on the back of this notice. Use the enclosed Request for Medicare Payment form the next time you wish to claim Medicare benefits.

You have met $60.00 of the Deductible for 1978

Always use both numbers when writing about your claim.

HI Number 063-54-8852A

CO Number 3122-25041

REMARKS:

BENEFICIARY OR REPRESENTATIVE

GEORGE WILLIAMS
PO BOX 1284
HARTFORD CT 06125

Now let's see how well you understand the EOMB. Mary Gray has submitted six itemized bills, each representing a visit to Dr. Green's office for an injection at $12 per visit between May 15, 1978 and August 10, 1978. Assume they are covered services and that Mary has already met her deductible. Complete the omitted figures in the outlined boxes below. Answers are on the next page.

NOTE: You will notice that there are not six items of $12 each on the EOMB. Since the visits entailed the same medical procedure they were grouped under the dates 05-15 to 08-10-78 and totalled at $72.00.

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM. KEEP THIS NOTICE FOR YOUR RECORDS

DATE	HEALTH INSURANCE NUMBER	CONTROL NUMBER
21 NOV 78	112-38-6541D	4011-25163 1

BENEFICIARY: MARY GRAY

AMOUNT PAID

BENEFITS HAVE BEEN PAID TO

MARY GRAY
45 OLD COURT RD
ROCHESTER NY 14618

FOR HEALTH INSURANCE
SOCIAL SECURITY ACT

THIS IS NOT A CHECK
DO NOT CASH

1. SERVICES WERE PROVIDED BY	2. WHEN FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	3. AMOUNT BILLED	4. AMOUNT APPROVED	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4. MEDICARE DOES NOT PAY FOR:	SERVICE CODES (see back)	CODE
DR GREEN	05	15	08	10	8	72.00	72.00		1	A

THIS IS NOT A BILL

TOTALS ►	72.00	72.00	MEDICARE PAID
Inpatient radiology and pathology physician services and certain laboratories paid in full ►			
Other approved charges, subject to the annual deductible ►			
This went toward satisfying the deductible ►			
The approved charges, minus the deductible, payable at 80% ►			
Date NOV 21, 1978 — TOTAL MEDICARE PAYMENT ►			

Please be sure to read the important information on the back of this notice. Use the enclosed Request for Medicare Payment form the next time you wish to claim Medicare benefits.

You have met _____ of the Deductible for

Always use both numbers when writing about your claim.

HI Number 112-38-6541D

CO Number 4011-25163

REMARKS:

BENEFICIARY OR REPRESENTATIVE

MARY GRAY
45 OLD COURT RD
ROCHESTER NY 14618

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM. KEEP THIS NOTICE FOR YOUR RECORDS

DATE	HEALTH INSURANCE NUMBER	CONTROL NUMBER
21 NOV 78	112-38-6541D	4011-25163 1

BENEFICIARY: MARY GRAY

AMOUNT PAID:

BENEFITS HAVE BEEN PAID TO

MARY GRAY
45 OLD COURT RD
ROCHESTER NY 14618

FOR HEALTH INSURANCE
SOCIAL SECURITY ACT

THIS IS NOT A CHECK
DO NOT CASH

1. SERVICES WERE PROVIDED BY	2. WHEN FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	3. AMOUNT BILLED	4. AMOUNT APPROVED	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4. MEDICARE DOES NOT PAY FOR:	SERVICE CODES (see back)	CODE
DR GREEN	05	15	08	10	8	72.00	72.00		1	A

THIS IS NOT A BILL

TOTALS ►	72.00	72.00	MEDICARE PAID
Inpatient radiology and pathology physician services and certain laboratories paid in full ►			
Other approved charges, subject to the annual deductible ►		72.00	
This went toward satisfying the deductible ►		00.00	
The approved charges, minus the deductible, payable at 80% ►		72.00	57.60
Date NOV 21, 1978 — TOTAL MEDICARE PAYMENT ►			57.60

Please be sure to read the important information on the back of this notice. Use the enclosed Request for Medicare Payment form the next time you wish to claim Medicare benefits.

You have met $60.00 of the Deductible for 1978

Always use both numbers when writing about your claim.

HI Number 112-38-6541D

CO Number 4011-25163

REMARKS:

BENEFICIARY OR REPRESENTATIVE

MARY GRAY
45 OLD COURT RD
ROCHESTER NY 14618

EXPLANATION: Mary's six visits multiplied by $12 per visit totals $72.00, all covered services. Since the deductible had already been met, the space opposite "This went toward satisfying the deductible" was left blank. The balance, of course, was $72.00, since nothing was taken out for the deductible. 80% of $72.00 is $57.60.

Ready for another one? Carl Harrison visited his physician, Dr. Anson, four times between 4-3-78 and 7-12-78 for covered services as follows:

4-3-78	injection	$10
4-15-78	blood tests	$15
6-5-78	blood tests	$15
7-12-78	injection	$10

Carl submitted the four bills on a HCFA-1490 to the carrier on 7-15-78. At the time, Carl had already accumulated $45 in covered services in the first two months of 1978 and had forwarded the bills on a previous HCFA-1490 in March, 1978. Complete the outlined boxes on the EOMB below. Assume charges are determined to be reasonable charges.

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM. KEEP THIS NOTICE FOR YOUR RECORDS

DATE	HEALTH INSURANCE NUMBER	CONTROL NUMBER
03 AUG 78	377-01-7047A	3361-50719 1

BENEFICIARY: CARL HARRISON

AMOUNT PAID:

BENEFITS HAVE BEEN PAID TO

CARL HARRISON
111 NEMO RD
BOSTON MASS 02149

FOR HEALTH INSURANCE
SOCIAL SECURITY ACT

THIS IS NOT A CHECK
DO NOT CASH

1. SERVICES WERE PROVIDED BY	2. WHEN FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	3. AMOUNT BILLED	4. AMOUNT APPROVED	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4. MEDICARE DOES NOT PAY FOR:	SERVICE CODES (see back)	CODE
DR ANSON	04	03	07	12	8	20.00	20.00		1	A
DR ANSON	04	15	06	05	8	30.00	30.00		1	A

THIS IS NOT A BILL

TOTALS ▶	50.00	50.00	MEDICARE PAID
Inpatient radiology and pathology physician services and certain laboratories paid in full ▶			
Other approved charges, subject to the annual deductible ▶			
This went toward satisfying the deductible ▶			
The approved charges, minus the deductible, payable at 80% ▶			
Date AUG 3, 1978 TOTAL MEDICARE PAYMENT ▶			

Please be sure to read the important information on the back of this notice. Use the enclosed Request for Medicare Payment form the next time you wish to claim Medicare benefits.

You have met of the Deductible for

Always use both numbers when writing about your claim.

HI Number 377-01-7047A

CO Number 3361-50719

REMARKS:

BENEFICIARY OR REPRESENTATIVE

CARL HARRISON
111 NEMO RD
BOSTON MASS 02149

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM. KEEP THIS NOTICE FOR YOUR RECORDS

DATE	HEALTH INSURANCE NUMBER	CONTROL NUMBER
03 AUG 78	377-01-7047A	3361-50719 1

BENEFICIARY
CARL HARRISON

AMOUNT PAID

BENEFITS HAVE BEEN PAID TO

CARL HARRISON
111 NEMO RD
BOSTON MASS 02149

FOR HEALTH INSURANCE
SOCIAL SECURITY ACT

THIS IS NOT A CHECK
DO NOT CASH

SERVICES WERE PROVIDED BY	2. WHEN FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	3. AMOUNT BILLED	4. AMOUNT APPROVED	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4. MEDICARE DOES NOT PAY FOR:	SERVICE CODES (see back)	CODE
DR ANSON	04	03	07	12	8	20.00	20.00		1	A
DR ANSON	04	15	06	05	8	30.00	30.00		1	A

THIS IS NOT A BILL

TOTALS ►	50.00	50.00	MEDICARE PAID
Inpatient radiology and pathology physician services and certain laboratories paid in full ►			
Other approved charges, subject to the annual deductible ►		50.00	
This went toward satisfying the deductible ►		15.00	
The approved charges, minus the deductible, payable at 80% ►		35.00	28.00
Date AUG 3, 1978 TOTAL MEDICARE PAYMENT ►			28.00

Please be sure to read the important information on the back of this notice. Use the enclosed Request for Medicare Payment form the next time you wish to claim Medicare benefits.

You have met $60.00 of the Deductible for 1978

Always use both numbers when writing about your claim.
HI Number 377-01-7047A
CO Number 3361-50719

REMARKS:

BENEFICIARY OR REPRESENTATIVE

CARL HARRISON
111 NEMO RD
BOSTON MASS 02149

EXPLANATION: The four charges totalled $50 all of which is subject to the deductible and coinsurance. Since Carl already had $45 applied toward his deductible from earlier in the year he needed $15 more to satisfy his deductible. Therefore, $15 was subtracted from the $50 listed on this EOMB leaving $35. Medicare paid 80% of this amount to Carl, or $28.

NOTE: Did you notice that there were two separate line items for Dr. Anson? Reason -- There were two medical procedures involved, injections and blood tests. It is required that these be shown separately on the EOMB.

Now let's review an EOMB that processes a charge determined to be greater than the reasonable charge for a particular service.

Josephine Kerr had an accident at home, required stitches, and drove herself to Dr. Lash's office for services. Dr. Lash submitted the bill to the carrier (assignment method of payment). The carrier determined the reasonable charge to be $30. Column 3 shows Dr. Lash's actual charge, column 4 shows the reasonable charge, and column 5 displays the standard language generated by the computer to refer the beneficiary to the reasonable charge explanation on the back of the page.

Assume that $50 of Josephine's deductible had been previously met. Complete the outlined boxes.

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM. KEEP THIS NOTICE FOR YOUR RECORDS

DATE	HEALTH INSURANCE NUMBER	CONTROL NUMBER
02 MAY 78	524-50-7401A	7777-03261 1

BENEFICIARY: JOSEPHINE KERR

AMOUNT PAID:

BENEFITS HAVE BEEN PAID TO

SAMUEL LASH MD
10021 STATE ST
ERIE PA 16508

FOR HEALTH INSURANCE
SOCIAL SECURITY ACT

THIS IS NOT A CHECK
DO NOT CASH

1. SERVICES WERE PROVIDED BY	2. WHEN FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	3. AMOUNT BILLED	4. AMOUNT APPROVED	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4. MEDICARE DOES NOT PAY FOR:	SERVICE CODES (see back)	CODE
DR LASH			04	03	8	40.00	30.00	SEE PARAGRAPH 5 ON BACK	1	A

THIS IS NOT A BILL

NOTE: When this computer generated language appears on the EOMB, the beneficiary is referred to the back of the form for the explanation of reasonable charge.

TOTALS ▶	40.00	30.00	MEDICARE PAID
Inpatient radiology and pathology physician services and certain laboratories paid in full ▶			
Other approved charges, subject to the annual deductible ▶			
This went toward satisfying the deductible ▶			
The approved charges, minus the deductible, payable at 80% ▶			
Date MAY 2, 1978 — TOTAL MEDICARE PAYMENT ▶			

Please be sure to read the important information on the back of this notice. Use the enclosed Request for Medicare Payment form the next time you wish to claim Medicare benefits.

You have met of the Deductible for

Always use both numbers when writing about your claim.

HI Number 524-50-7401A

CO Number 7777-03261

REMARKS:

BENEFICIARY OR REPRESENTATIVE

JOSEPHINE KERR
21 8TH ST
ERIE PA 16501

Now let's see how much you remember from earlier instruction in this text. How much is Dr. Lash allowed to bill Josephine for his service after receiving reimbursement from the carrier?

Ans. _____

EXPLANATION OF MEDICARE BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM. KEEP THIS NOTICE FOR YOUR RECORDS

DATE	HEALTH INSURANCE NUMBER	CONTROL NUMBER
02 MAY 78	524-50-7401A	7777-03261 1

BENEFICIARY
JOSEPHINE KERR

AMOUNT PAID

BENEFITS HAVE BEEN PAID TO

SAMUEL LASH MD
10021 STATE ST
ERIE PA 16508

FOR HEALTH INSURANCE
SOCIAL SECURITY ACT

THIS IS NOT A CHECK
DO NOT CASH

1. SERVICES WERE PROVIDED BY	2. WHEN FROM MO.	FROM DAY	TO MO.	TO DAY	TO YR.	3. AMOUNT BILLED	4. AMOUNT APPROVED	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4. MEDICARE DOES NOT PAY FOR:	SERVICE CODES (see back)	CODE
DR LASH			04	03	8	40.00	30.00	SEE PARAGRAPH 5 ON BACK	1	A

THIS IS NOT A BILL

TOTALS ►	40.00	30.00	MEDICARE PAID
Inpatient radiology and pathology physician services and certain laboratories paid in full ►			
Other approved charges, subject to the annual deductible ►		30.00	
This went toward satisfying the deductible ►		10.00	
The approved charges, minus the deductible, payable at 80% ►		20.00	
Date MAY 2, 1978 TOTAL MEDICARE PAYMENT ►			

Please be sure to read the important information on the back of this notice. Use the enclosed Request for Medicare Payment form the next time you wish to claim Medicare benefits.

You have met $60.00 of the Deductible for 1978

Always use both numbers when writing about your claim.
HI Number 524-50-7401A
CO Number 7777-03261

REMARKS:

BENEFICIARY OR REPRESENTATIVE

JOSEPHINE KERR
21 8th ST
ERIE PA 16501

Answer to question: $14. Dr. Lash must accept $30 as the total charge for his services. Since the carrier reimbursed him $16, he is allowed to bill Josephine for the difference. Remember, this was an assignment case.

Underpayments for medical insurance benefits due a deceased beneficiary are taken care of in two ways, depending on whether the bill has or has not been paid. If the physician's bill is unpaid, the Medicare payment may be made only to the physician and only if she agrees to accept the reasonable charge for the service as the full charge (i.e., accepts assignment). Thus, under certain circumstances, underpayments can be paid directly to the _____.	physician
Jackson Andress, who had already met the $60 SMI deductible, was under the care of Dr. Jones when he died. Dr. Jones had performed covered services for fees totaling $325. The reasonable charges for these services are determined to be $287. Since the bill is unpaid, Dr. Jones can claim reimbursement for $_____, if he accepts $287 as his full charge.	229.60 (80% of $287)
If the medical bill has been paid, the law sets up a standard list of priority for the SMI underpayment: 1. Payment to the person who paid the bill. 2. Payment to the legal representative of the beneficiary's estate. 3. Payment to certain relatives of the beneficiary. GO ON TO NEXT FRAME	
The first person to whom SMI underpayments will be made if the medical bill has been paid is _____ _____ _____ _____ _____ _____.	the person who paid the bill
If the beneficiary had paid the bill or it was paid with funds of the estate, the first priority is the _____ _____ _____ _____ _____ _____.	legal representative of the beneficiary's estate

If the deceased beneficiary paid the bill, and there is no legal representative of the estate, the underpayment may be paid to certain relatives of the deceased beneficiary. GO ON TO NEXT FRAME	
To review, underpayments for: Unpaid bills may be paid only to the _____ . . .	physician
. . . if the physician agrees to accept the _____ charge as the full charge.	reasonable
Underpayments for: Paid bills must be made in this priority: If paid by a person other than the deceased beneficiary, a. to the _____ who _____the bills, or . . .	person, paid
b. . . . . if paid by the beneficiary or with funds from the beneficiary's estate, to the _____ _____ of the beneficiary's estate, or . . .	legal representative

c. . . . if there is no legal representative, to _____ _____ __ ____ _____. GO ON TO NEXT FRAME	certain relatives of the beneficiary
A person who has been denied supplementary medical insurance benefits (Part B) may appeal the determination made on the claim. A beneficiary has the right to question the decision made on any Part B claim. Whether you think the beneficiary has a chance of gaining a favorable decision does not matter; the law still gives the beneficiary the right to disagree and to file an appeal. READ ON	
Before helping a beneficiary file an appeal, you should first get the facts, then explain the reason for the determination made on the claim. If the beneficiary is still not satisfied that the decision was a correct one, you should help the beneficiary file the appeal. An early step in any potential appeal interview is giving the beneficiary full _____ of the determination made on the claim.	explanation
Once the decision to file an appeal on a Part B claim has been made, you must identify the issue as one of: (1) basic entitlement to Part B, or (2) benefits payable under Part B. The appeals process is different for (1) and (2) above. For issues involving basic entitlement to Part B, and for those involving the amount of benefits payable under Part B, the appeals process _____ (is/is not) the same.	is not
Some examples of issues involving basic entitlement to Part B may include a beneficiary's date of birth (whether age 65), or a beneficiary's proper and timely enrollment for SMI. If one of these, or some other basic entitlement factor, is the disputed issue, the appeals process is the regular SSA appeals process. That is, it is the same as that followed in retirement, survivors, and disability insurance cases -- reconsideration, hearing, Appeals Council review, and judicial review. GO ON TO NEXT PAGE	

The appeals process is identical to that followed in RSDI cases when the claimant is denied benefits because of a factor of _____	entitlement
If, instead of basic entitlement to Part B, the issue involves the coverage of a service or the amount of benefits payable under Part B, the carrier appeals process applies. Since most Part B claims are processed by carriers, we will speak of this as simply the "carrier appeals process." READ ON	
This process contains two levels of appeal: first, a review by the carrier and second (if the beneficiary requests), a hearing by a hearing officer appointed by the carrier. GO ON TO NEXT FRAME	
A beneficiary who initially disagrees with the amount of Part B charges determined by the carrier to be the reasonable charges should file for a _____ by the _____.	review carrier
To request a-review by the carrier, the beneficiary should complete form HCFA-1964. Normally, this request must be made within 6 months of the beneficiary's notice of the initial determination on the claim (this time limit may be extended for "good cause"). GO ON TO NEXT PAGE	

Let's look at an example. On November 3, 1977, Mr. Thompson presents an EOMB dated July 30, 1977, from Travelers' Insurance Company showing that of $1,050.00 total physicians' charges submitted, $900.00 were the "charges allowed." Since the Part B deductible had already been met, the Medicare payment was $720.00. You explain "reasonable charges" to Mr. Thompson, but he is still not satisfied that the decision on his claim was a correct one, and he wants the situation looked into further. You should help him complete form _____ to request a carrier _____.	HCFA-1964 review
In Mr. Thompson's case, "good cause" does not have to be established because the request for review was filed by _____. (date)	January 30, 1978
On December 15, 1977, Mr. Thompson telephones the Social Security office. He has a notice from Traveler's dated December 14, 1977, stating that his claim has been reviewed and the original decision was determined to be correct. He still thinks he is entitled to $840.00 (80% of $1,050, the actual charges) instead of the $720.00 which Medicare paid. For you to know what action should be taken next, you need some further information. GO ON TO NEXT FRAME	
A carrier hearing should be requested on form HCFA-1965. Unless "good cause" can be established, the request must be filed within 6 months of the determination made on the review. The amount of benefits in controversy must be at least $100.00. Mr. Thompson _____ meet these requirements for requesting a carrier hearing. (does/does not)	does
Mr. Thompson should complete form _____ by _____. (date)	HCFA-1965 June 14, 1978

Let's check now. When a beneficiary contests the amount of benefits payable under Part B of Medicare, the carrier appeals process applies. This consists of two levels: A _____, and then a _____ by the carrier.	review, hearing
Generally, the request for review must be filed within _____ months of the initial determination, and the requests for hearing must be filed within _____ months of the decision on the review.	6 6
There is a provision for late filing of requests on both the review and the hearing. On either of these appeals, the time limit for filing may be extended for _____ _____.	good cause
A carrier review should be requested on form HCFA-_____ and a hearing on form HCFA-_____.	1964 1965
For a carrier hearing to be granted, the amount in controversy must be at least _____.	$100 (Note that no money limitation applies to a carrier review.)

Closely related to the Medicare appeals process is Medicare's "waiver of liability" provision. Before the 1972 amendments, whenever a Medicare claim was disallowed, the liability for payment for services fell upon the beneficiary. The result was that, in many cases, a beneficiary was liable for payment even though the beneficiary acted in good faith in accepting services which the beneficiary thought were covered under Medicare, only to find out later that they were not. The waiver of liability provision in the 1972 amendments was enacted to grant relief in this type of situation. GO ON TO NEXT FRAME	
Sometimes a beneficiary may be relieved of the responsibility for payment for services rendered which the beneficiary, in good faith, thought were covered under Medicare, but which were in fact not covered. This provision, made a part of Medicare in the 1972 amendments, is called _____ of _____.	waiver liability
The waiver of liability provision of Medicare may apply in both Part A and Part B claims. In this programmed learning text, we will discuss only how this provision applies to claims under Part B of Medicare. READ ON	
For a beneficiary's liability for payment for Part B services to be waived under this provision, all four of the following circumstances must exist: 1. The services were denied because they were determined not to be "medically reasonable and necessary"; 2. The beneficiary did not know, and could not reasonably have been expected to know, that the services in question were not covered; 3. The claim was an assigned claim; and 4. A Part B appeal is filed. GO ON TO NEXT FRAME	
In Part B claims in which the waiver of liability provision can apply, the denial must have been based on a determination that services were not medically _____ and _____.	reasonable necessary

A beneficiary, for example, who has been denied Medicare payment on an assigned claim for the fitting of dentures, whose dentist has assured the beneficiary that Medicare would cover the service, _____ be granted relief under the waiver of liability provision. (can/cannot)	cannot (The denial was not related to services being reasonable and necessary.)
This same beneficiary can, however, request a carrier review by filing form HCFA-1964 within 6 months of the initial denial. True or False.	True (Remember that any beneficiary has the right to question the decision on any claim, and to file the appropriate appeal.)
One final note. Remember that waiver of liability is not considered by the carrier unless the correctness of the decision made on the claim is questioned. For a carrier to consider this provision, the Part B appeals procedure must be followed. If you are assisting a beneficiary in filing a carrier appeal and the waiver of liability requirements seem to be met, you should point this out on the HCFA-1964 for a _____, and on the HCFA-1965 for a _____.	review, hearing
Congratulations. You have now completed the programmed learning text on Medical Insurance Benefits. If you have also completed the programmed learning text on Hospital Insurance Benefits, you should have a good general knowledge of both Part A and Part B of the Meidicare program.	

COMMENTS ON

MEDICAL INSURANCE BENEFITS/

A PROGRAMMED LEARNING TEXT

As a user of this booklet, your opinion on the following is solicited:

1. In what way did you find the book useful?

2. How would you improve the book?

3. What Medicare-related topics would you suggest for similar publications?

4. What is your organization and position?

Address comments to:

Bureau of Program Operations
Medicaid/Medicare Management Institute
389 East High Rise
Baltimore, Maryland 21235

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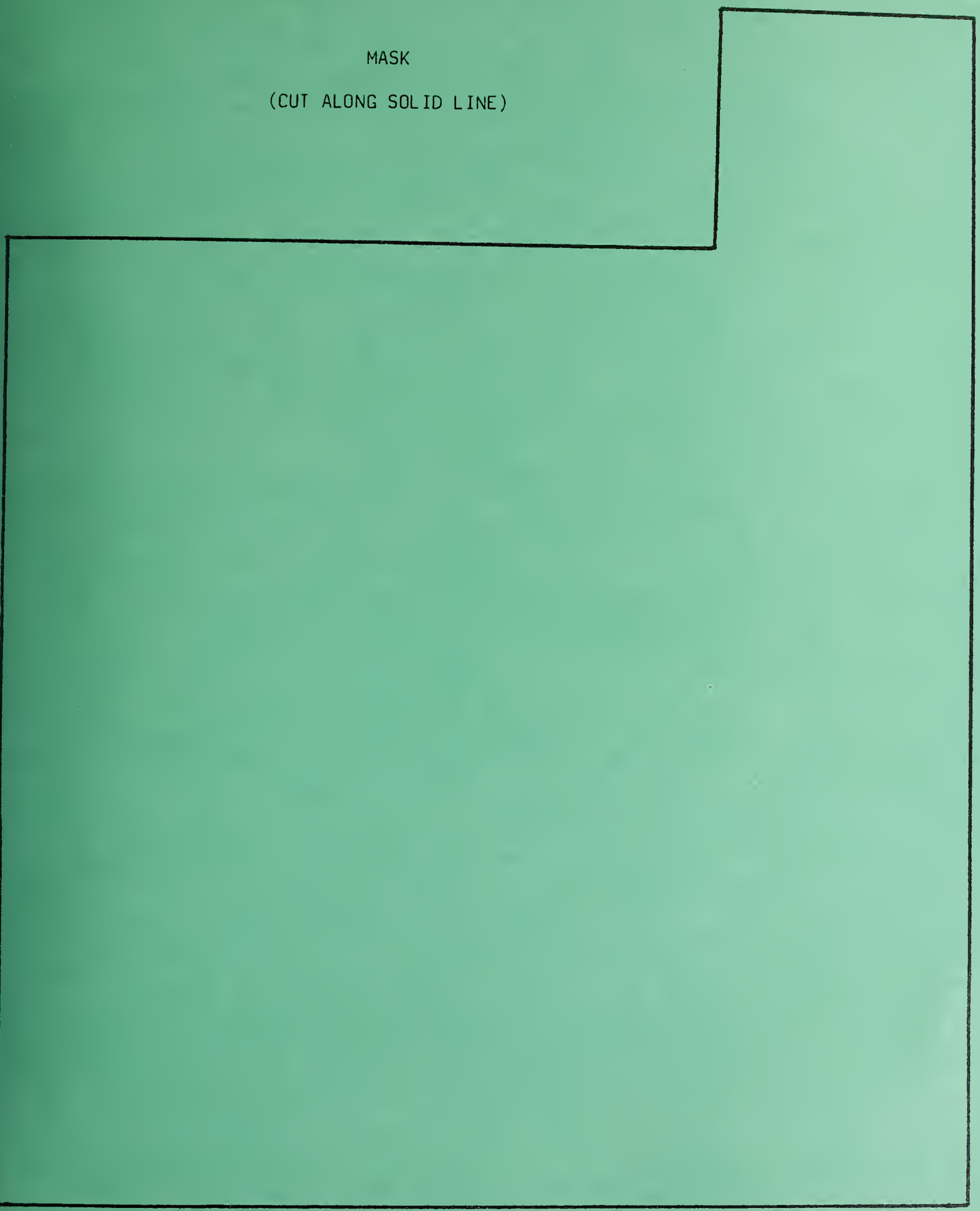

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